		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025577

Facility Name: Covenant Health Care Center-Batavia

Address: 831 North Batavia Avenue (Number) Batavia (City) 60510 (Zip Code)

County: Kane

Telephone Number: (630) 879-4300 **Fax #** (630) 879-8483

IDPA ID Number: 52-11158-73002

Date of Initial License for Current Owners: 05/09/80

Type of Ownership:

XX	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
XX	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Barry C. Scutillo, CPA **Telephone Number:** (954) 721-5222

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/01 to 01/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Richard W. Olson
(Title) Vice President, Finance

Paid Preparer
(Signed) See attached Accountant's Report (Date)
(Print Name and Title) Scutillo Blake McMillan & Joyce, PA
(Firm Name & Address) 8000 North University Drive, Fort Lauderdale, Fl 33321
(Telephone) (954) 721-5222 Fax # (954) 722-6692

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	49	Sheltered Care (SC)	49	17,885	5
6		ICF/DD 16 or Less			6
7	177	TOTALS	177	64,605	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,164	58	1,850	3,072	8
9	SNF/PED					9
10	ICF	7,961	27,970	0	35,931	10
11	ICF/DD					11
12	SC	0	8,831	0	8,831	12
13	DD 16 OR LESS					13
14	TOTALS	9,125	36,859	1,850	47,834	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.04%

D. How many bed-hold days during this year were paid by Public Aid?
24 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [XX] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 05/06/80

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [XX]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 128 and days of care provided 1,740

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 01/31/02 Fiscal Year: 01/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	388,371	43,759	(10,254)	421,876		421,876		421,876			1
2	Food Purchase		279,555		279,555		279,555		279,555			2
3	Housekeeping	228,679	25,518	2,719	256,916		256,916		256,916			3
4	Laundry	47,417	5,768	49,733	102,918		102,918		102,918			4
5	Heat and Other Utilities			128,644	128,644		128,644		128,644			5
6	Maintenance	89,906	13,700	90,671	194,277		194,277		194,277			6
7	Other (specify):*			60,905	60,905		60,905		60,905			7
8	**TOTAL General Services**	754,373	368,300	322,418	1,445,091		1,445,091		1,445,091			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	2,469,083	173,338	103,865	2,746,286		2,746,286		2,746,286			10
10a	Therapy		960	22,196	23,156		23,156		23,156			10a
11	Activities	127,683	3,924	30,959	162,566		162,566	(2,331)	160,235			11
12	Social Services	93,566	150		93,716		93,716		93,716			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,690,332	178,372	170,020	3,038,724		3,038,724	(2,331)	3,036,393			16
	C. General Administration											
17	Administrative	140,432		334,824	475,256	(23,416)	451,840	133,594	585,434			17
18	Directors Fees											18
19	Professional Services			44,033	44,033		44,033		44,033			19
20	Dues, Fees, Subscriptions & Promotions			48,243	48,243		48,243	(3,547)	44,696			20
21	Clerical & General Office Expenses	276,812	16,001	68,936	361,749		361,749	(11,986)	349,763			21
22	Employee Benefits & Payroll Taxes			666,455	666,455	23,416	689,871		689,871			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,364	11,364		11,364	(7,418)	3,946			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			84,150	84,150		84,150		84,150			26
27	Other (specify):*											27
28	**TOTAL General Administration**	417,244	16,001	1,258,005	1,691,250		1,691,250	110,643	1,801,893			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,861,949	562,673	1,750,443	6,175,065		6,175,065	108,312	6,283,377			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Covenant Health Care Center-Batavia #0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			188,127	188,127		188,127	21,226	209,353			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			485,076	485,076		485,076	(319,828)	165,248			32
33	Real Estate Taxes			17,298	17,298		17,298	(17,298)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,094	2,094		2,094		2,094			35
36	Other (specify):*											36
37	**TOTAL Ownership**			692,595	692,595		692,595	(315,900)	376,695			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	69,374	342,474	53,734	465,582		465,582		465,582			39
40	Barber and Beauty Shops			50,069	50,069		50,069		50,069			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							70,080	70,080			42
43	Other (specify):*	4,075		17,151	21,226		21,226	(21,226)				43
44	**TOTAL Special Cost Centers**	73,449	342,474	120,954	536,877		536,877	48,854	585,731			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,935,398	905,147	2,563,992	7,404,537		7,404,537	(158,734)	7,245,803			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,014)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,226	30		9
10	Interest and Other Investment Income	(335,962)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(37,658)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (362,408)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	133,594		34
35	Other- Attach Schedule **Provider Part. Fee**	70,080	42	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 203,674		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (158,734)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Covenant Health Care Center-Batavia

ID# 0025577

Report Period Beginning: 02/01/01

Ending: 01/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending, Personal Service, Other Operating Rev	$ (1,972)	21	1
2	Transportation Revenue Offset	(1,134)	11	2
3	Emp. Recognition, Marketing Exp	(21,226)	43	3
4	Flowers, Cable TV Access	(1,197)	11	4
5	Dues, Subscriptions, Public Relations	(3,547)	20	5
6	Travel & Seminar	(7,418)	24	6
7	Amortize Loss on Early Retirement of Debt	16,134	32	7
8	Real Estate Taxes	(17,298)	33	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(37,658)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,331)	0	0	0	0	0	0	0	0	0	0	(2,331)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,331)	0	0	0	0	0	0	0	0	0	0	(2,331)	16
	C. General Administration													
17	Administrative	0	133,594	0	0	0	0	0	0	0	0	0	133,594	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,547)	0	0	0	0	0	0	0	0	0	0	(3,547)	20
21	Clerical & General Office Expenses	(11,986)	0	0	0	0	0	0	0	0	0	0	(11,986)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,418)	0	0	0	0	0	0	0	0	0	0	(7,418)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,951)	133,594	0	0	0	0	0	0	0	0	0	110,643	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,282)	133,594	0	0	0	0	0	0	0	0	0	108,312	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	21,226	0	0	0	0	0	0	0	0	0	0	21,226	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(319,828)	0	0	0	0	0	0	0	0	0	0	(319,828)	32
33	Real Estate Taxes	(17,298)	0	0	0	0	0	0	0	0	0	0	(17,298)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(315,900)	0	0	0	0	0	0	0	0	0	0	(315,900)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	70,080	0	0	0	0	0	0	0	0	0	0	70,080	42
43	Other (specify):*	(21,226)	0	0	0	0	0	0	0	0	0	0	(21,226)	43
44	**TOTAL Special Cost Centers**	48,854	0	0	0	0	0	0	0	0	0	0	48,854	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(292,328)	133,594	0	0	0	0	0	0	0	0	0	(158,734)	45

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Communities	100%	See Attached Schedule	Various	Cov Retire. Comm	Chicago	Mgt Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [XX] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Services	$ 334,824	Covenant Retirement Communities, Inc.	100.00%	$ 468,418	$ 133,594	1
2	V	19	Consulting Services	44,033	Covenant Retirement Communities, Inc.	100.00%		(44,033)	2
3	V		Detail:						3
4	V	19	Data Processing Service				21,744	21,744	4
5	V	19	Audit Service				7,259	7,259	5
6	V	19	Cost Report Preparation				5,941	5,941	6
7	V	19	Payroll Processing				9,089	9,089	7
8	V								8
9	V	22	Pension Expense	5,808	Covenant Retirement Communities, Inc.	100.00%	5,808		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 384,665			$ 518,259	$ * 133,594	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [XX] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Retirement Communities, Inc.
Street Address: 5115 N. Francisco Ave., Suite 200
City / State / Zip Code: Chicago, Illinois 60625
Phone Number: (773) 878-2294
Fax Number: (773) 878-2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	17	Management Fees	Net Service Revenue	94,856,000	32	5,391,331	1,938,624	6,069,567	334,824	2
3										3
4	19	Data Processing	Fixed Fee Per Mo (1)	32	32	474,064	Not Available	1	21,744	4
5	19	Auditing Services	Fixed Fee Per Mo (2)	32	32	241,647	0	1	7,259	5
6	19	Cost Report Preparation	Fixed Fee Per Mo (3)	14	14	66,456	0	1	5,941	6
7	19	Payroll Services	Dir. Cost From Vendor	1	1	9,089	0	1	9,089	7
8										8
9	22	Pension Expense	Fixed Fee Per Mo (4)	32	32	125,977	0	1	5,808	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20		(1) Data processing is based upon a fixed fee of $1,812 per month.								20
21		(2) Auditing services are based upon a fixed fee of $605 per month.								21
22		(3) Cost report preparation services are based upon a fixed fee of $495 per month.								22
23		(4) Pension Plan expenses are based upon an estimated fee of $484 per month.								23
24										24
25	TOTALS					$ 6,308,564	$ 1,938,624		$ 384,665	25

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	See Supplemental Schedule I						$ 29,385,064	$ 27,956,101			$ 606,411	1
2	See Supplemental Schedule II						1,267,551	1,151,208			90,246	2
3												3
4												4
5												5
	Working Capital											
6	Interco Notes To/From CRC	XX		Working Capital	O/S Balance	02/01/94	(3,959,933)	(7,436,039)	n/a	variable		6
7												7
8												8
9	TOTAL Facility Related						$ 26,692,682	$ 21,671,270			$ 696,657	9
	B. Non-Facility Related*											
10	Interest Income Offset										(335,962)	10
11												11
12	Amort of Loss on EE of Debt										16,134	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (319,828)	14
15	TOTALS (line 9+line14)						$ 26,692,682	$ 21,671,270			$ 376,829	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** **N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 19,169	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 17,298	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,871)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 19,169	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 17,298	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998	12,299	9
1999	14,416	10
2000	15,549	11
2001	14,161	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Health Care Center-Batavia COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0025577

CONTACT PERSON REGARDING THIS REPORT Barry C. Scutillo, CPA

TELEPHONE (954) 721-5222 FAX #: (954) 722-6692

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-15-177-012	Covenant Health Care Center, Inc.	$ 17,298.00	$ 17,298.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 17,298.00	$ 17,298.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES XX NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,884 B. General Construction Type: Exterior Masonary - Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [XX] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [XX] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

The Homstad is a residential independent living facility for senior adults: 302,869 square feet and 318 units.
Park Manor is a division of the residential independent living facility which has assisted services for senior adults: 44 out of 64 apartments in Building F
Colonial House is a sheltered care faciltiy licensed for 49 beds; 29,647 square feet and 27 rooms.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [XX] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1979-1980	$ 86,624	1
2					2
3	TOTALS			$ 86,624	3

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1980	1980	$ 2,454,000	$ 76,388	33	$ 74,364	$ (2,024)	$ 1,598,454	4
5	49		1977	1977	818,006	24,535	33	24,788	253	600,370	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Michealsen			1982	8,904	145	30	297	152	5,589	9
10				1983	17,320	532	30	577	45	10,441	10
11				1984	1,040		10			1,040	11
12				1988	9,128		10			9,128	12
13				1989	18,984		10			18,984	13
14				1990	40,083		10			40,083	14
15				1991	18,354	918	10	912	(6)	18,354	15
16				1992	18,931	1,893	10	1,893		17,984	16
17				1993	90,076	4,504	10	9,008	4,504	76,568	17
18				1994	56,935	2,847	10	5,694	2,847	42,705	18
19				1995	84,370	4,219	10	8,438	4,219	54,847	19
20	Window Treatment			1996	9,675	484	10	967	483	5,319	20
21	Cubicle Curtain			1997	544	27	10	54	27	267	21
22	Door			1997	378	19	10	38	19	169	22
23	Cubicle Curtain			1997	3,495	175	10	350	175	1,444	23
24	Cubicle Curtain			1997	153	8	10	15	7	74	24
25	Locks for Lockers			1998	1,514	76	10	151	75	604	25
26	Awnings for Patio			1998	1,428	71	10	143	72	498	26
27	Awnings for Patio			1998	1,428	71	10	143	72	477	27
28	Cafe Wallpaper			1998	852	43	10	85	42	287	28
29	Permit for UST Installation			1998	528	26	10	53	27	172	29
30	Kitchen Renovation			1999	912	46	10	91	45	269	30
31	Kitchen Renovation - Counter			1999	1,269	63	10	127	64	325	31
32	Awnings			1999	938	47	10	94	47	222	32
33	Awnings			1999	938	47	10	94	47	214	33
34	Smoking Area Recepticles			1999	467	23	10	47	24	106	34
35	Window Cornice			1999	569	28	10	57	29	129	35
36	Countertops & Sinks			2000	2,810	141	10	281	140	549	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	6 Wire Shelf Truck	2000	$ 1,002	$ 50	10	$ 100	$ 50	$ 192	37
38	Ceiling Fans	2000	1,870	94	10	187	93	304	38
39	Door Lock	2000	1,532	77	10	153	76	228	39
40	Roof Repair	2000	2,597	130	10	260	130	304	40
41									41
42	Building Improvements - Colonial House								42
43		1982	4,198	148	30	140	(8)	2,869	43
44		1983	657	24	30	22	(2)	427	44
45		1984	208		10			208	45
46		1986	29,215		10			29,215	46
47		1987	21,856		10			21,856	47
48		1988	11,310		10			11,310	48
49		1990	4,698		10			4,698	49
50		1991	1,227		10			1,227	50
51		1992	2,991	150	10	150		2,991	51
52		1994	7,673	384	10	767	383	6,521	52
53		1995	150	7	10	15	8	112	53
54	Carpeting	1996	18,620	931	10	1,862	931	10,929	54
55	Drapes	1997	1,883	94	10	188	94	927	55
56	Carpeting	1997	210	11	10	21	10	104	56
57	Carpeting	1997	537	27	10	54	27	253	57
58	Carpeting	1997	2,511	126	10	251	125	1,176	58
59	Bathroom Tile	1997	139	7	10	14	7	65	59
60	Carpeting	1997	1,331	66	10	133	67	612	60
61	Carpeting	1997	245	12	10	25	13	110	61
62	Drapes	1998	203	10	10	20	10	74	62
63	Permit for UST Installation	1998	72	4	10	7	3	23	63
64	Drapes	1999	10,490	525	10	1,049	524	3,075	64
65	Carpeting	1999	256	13	10	26	13	74	65
66	Carpeting	1999	450	23	10	45	22	118	66
67	Floor Covering	1999	244	12	10	24	12	49	67
68	Toilet	1999	174	9	10	17	8	35	68
69	Floor Covering	2000	268	13	10	27	14	54	69
70	TOTAL (lines 4 thru 69)		$ 3,792,846	$ 120,323		$ 134,318	$ 13,995	$ 2,605,812	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,792,846	$ 120,323		$ 134,318	$ 13,995	$ 2,605,812	1
2	Border	2000	1,511	75	10	151	76	226	2
3	Crypton Fabric	2000	449	22	10	45	23	63	3
4	Wall Covering	2000	227	11	10	23	12	32	4
5	Window Treatment	2000	4,178	209	10	418	209	538	5
6	Roof Repair	2000	7,509	375	10	751	376	957	6
7	Bath Floor	2001	234	6	10	12	6	12	7
8	Sheers - Rm 28	2001	365	9	10	18	9	18	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,807,319	$ 121,030		$ 135,736	$ 14,706	$ 2,607,658	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,807,319	$ 121,030		$ 135,736	$ 14,706	$ 2,607,658	1
2									2
3	Land Improvements - Michealsen	1982	780	19	20	39	20	732	3
4		1986	14,644		20	732	732	11,648	4
5		1987	12,022		20	601	601	9,127	5
6		1988	1,368	68	20	68		1,012	6
7		1989	520	32	20	26	(6)	364	7
8		1989	17,748	827	20	888	61	11,100	8
9		1990	4,592	155	20	230	75	2,645	9
10		1991	11,423	697	20	571	(126)	5,996	10
11	Adjustment for prior year disposal of assets					4,351	4,351		11
12									12
13	Land Improvements - Colonial House	1990	3,528	176	20	177	1	2,207	13
14		1991	2,508	125	20	125		1,441	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,876,452	$ 123,129		$ 143,544	$ 20,415	$ 2,653,930	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 673,975	$ 63,280	$ 64,091	$ 811	10	$ 271,996	71
72	Current Year Purchases	34,354	1,718	1,718		10	1,718	72
73	Fully Depreciated Assets	466,591				10	466,591	73
74								74
75	TOTALS	$ 1,174,920	$ 64,998	$ 65,809	$ 811		$ 740,305	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,137,996	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 188,127	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 209,353	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,226	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,394,235	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [XX] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [XX] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [XX] NO

16. Rental Amount for movable equipment: $ 2,094 Description: Equipment Rental (Sch V, Line 35)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [XX] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	hrs	$	454	$	18,296	$	454	$ 18,296	1
2	Licensed Speech and Language Development Therapist	10A	hrs		65		2,710		65	2,710	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A	hrs		28		1,190		28	1,190	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39	# of prescrpts		12,663			340,482	12,663	340,482	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Lab & X-Ray	39			576		53,734		576	53,734	13
14	TOTAL			$	13,786	$	75,930	$ 340,482	13,786	$ 416,412	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 01/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,965,521	$ 7,695,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	638,011	8,478,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		9,136,000	5
6	Prepaid Insurance	5,510		6
7	Other Prepaid Expenses		1,388,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,609,042	$ 26,697,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		94,468,000	12
13	Land	128,148	15,815,000	13
14	Buildings, at Historical Cost	3,940,052	317,757,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	680,046	44,147,000	16
17	Accumulated Depreciation (book methods)	(2,851,016)	(123,145,000)	17
18	Deferred Charges	1,152,222		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	14,726,089	39,547,000	21
22	Other Long-Term Assets (specify):		20,064,000	22
23	Other(specify): Construction In Progress	5,892,416	27,451,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 23,667,957	$ 436,104,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 27,276,999	$ 462,801,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 602,906	$ 6,267,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		2,819,000	28
29	Short-Term Notes Payable		7,685,000	29
30	Accrued Salaries Payable	199,110	3,014,000	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,375		32
33	Accrued Interest Payable	380,908	1,540,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	12,389	3,426,000	36
37	Current Maturities, LTD	140,401	5,370,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,361,089	$ 30,121,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	27,815,700		40
41	Bonds Payable		194,901,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany accts, other liabilities	(7,342,145)	12,340,000	43
44	Deferred Revenue		159,421,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 20,473,555	$ 366,662,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 21,834,644	$ 396,783,000	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,442,355	$ 66,018,000	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 27,276,999	$ 462,801,000	48

***(See instructions.)**

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,121,211	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,121,211	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	322,722	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Planned Giving Assessments**	(1,581)	15
16	Other (describe) **Rounding**	3	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 321,144	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,442,355	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,034,161	1
2	Discounts and Allowances for all Levels	(818,249)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,215,912	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,334	6
7	Oxygen	14,142	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 281,476	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	58,173	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	10,014	15
16	Rental of Facility Space		16
17	Sale of Drugs	380,652	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	124,691	19
20	Radiology and X-Ray		20
21	Other Medical Services	205,398	21
22	Laundry	77,685	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 856,613	23
	D. Non-Operating Revenue		
24	Contributions	15,528	24
25	Interest and Other Investment Income***	335,963	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 351,491	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Equipment Rental	18,661	28
28a	See attached list	3,106	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,767	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,727,259	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,445,091	31
32	Health Care	3,038,724	32
33	General Administration	1,691,250	33
	B. Capital Expense		
34	Ownership	692,595	34
	C. Ancillary Expense		
35	Special Cost Centers	536,877	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,404,537	40
41	**Income before Income Taxes (line 30 minus line 40)****	322,722	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 322,722	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,896	4,279	$ 133,730	$ 31.25	1
2	Assistant Director of Nursing	9,033	9,842	235,788	23.96	2
3	Registered Nurses	46,986	51,643	980,363	18.98	3
4	Licensed Practical Nurses	3,251	3,586	67,269	18.76	4
5	Nurse Aides & Orderlies	69,198	77,292	989,732	12.81	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,193	2,497	69,374	27.78	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,843	3,137	43,817	13.97	9
10	Activity Assistants	5,691	6,273	71,594	11.41	10
11	Social Service Workers	5,616	6,276	93,566	14.91	11
12	Dietician					12
13	Food Service Supervisor	5,375	6,181	104,106	16.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,557	29,953	284,265	9.49	15
16	Dishwashers					16
17	Maintenance Workers	4,045	4,926	89,906	18.25	17
18	Housekeepers	21,481	23,599	228,679	9.69	18
19	Laundry	3,512	3,869	47,417	12.26	19
20	Administrator	2,958	3,320	140,432	42.30	20
21	Assistant Administrator					21
22	Other Administrative	1,712	1,980	38,328	19.36	22
23	Office Manager	1,804	2,120	33,853	15.97	23
24	Clerical	13,012	14,839	204,631	13.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,896	2,151	31,955	14.86	31
32	Other Health Care(specify)					32
33	Other(specify)	3,252	3,662	46,593	12.72	33
34	TOTAL (lines 1 - 33)	235,311	261,425	$ 3,935,398 *	$ 15.05	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	127	$ 3,803	Ln 1, Col 3	35
36	Medical Director	Monthly	13,000	Ln 9, Col 3	36
37	Medical Records Consultant	Monthly	4,040	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,416	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	2	58	Ln 11, Col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	129	$ 22,317		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	262	$ 11,549	Ln 10, Col 3	50
51	Licensed Practical Nurses	475	15,254	Ln 10, Col 3	51
52	Nurse Aides	2,503	60,787	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	3,240	$ 87,590		53

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Larson	Administrator	0%	$ 58,578
John Currier	Administrator	0%	16,129
Susan Graunke	Administrator	0%	42,309
Add: Reclass Fringe Benefits			23,416
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,432

B. Administrative - Other

Description	Amount
Covenant Retirement Communities, Inc.	$ 334,824
TOTAL (agree to Schedule V, line 17, col. 3)	$ 334,824
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche	Auditing Services	$ 7,259
A.D.P.	Payroll Services	9,089
Covenant Retire. Comm.	Data Process Services	21,744
Scutillo Blake McMillan		
& Joyce, PA	Cost Report Prep	5,941
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 44,033

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,236
Unemployment Compensation Insurance	13,646
FICA Taxes	265,268
Employee Health Insurance	320,172
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	13,274
Pension Plan	5,808
Other	16,051
Reclass Administrator Fringe Benefits	23,416
TOTAL (agree to Schedule V, line 22, col.8)	$ 689,871

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	24,263
Health Care Worker Background Check	
(Indicate # of checks performed)	
Promotion/Public Relations	2,970
Dues & Subscriptions	21,010
Less: Unallowable Dues/Subscriptions	(577)
Less: Public Relations Expense	(2,970)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,696

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 4,806
Unallowable Out of State Travel	(4,806)
In-State Travel	1,812
Unallowable In-State Travel	(878)
Seminar Expense	4,746
Unallowable Seminar Expense	(1,734)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,946

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/01 Ending: 01/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $10,447**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,322** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **XX** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **XX** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **70,080**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,555**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Deloitte & Touche LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.